Idaho State Department of Education / Child Nutrition Programs
P.O. Box 83720
Boise, ID 83720-0027
Phone: (208) 332-6820
Fax: (208) 334-2228

User Authorization Request

Instructions: Complete and return to SDE-Child Nutrition Programs. Retain a copy for your files.

Representing: _____
Sponsor Name(s)

User Name: _____ Title: _____
First, M.I. Last

User ID: _____
Example: First seven letters of last name + first letter of first name. PLEASE WRITE LEGIBLY!

Password: _____
Up to twelve characters long. Number and/or letters. Not related to name. PLEASE WRITE LEGIBLY!
Note: Passwords must be changed annually (CNP2000 will prompt you when you must change it).

Email Address: _____ Phone: (____) _____

Reminder Question: _____ Answer: _____
A question only you would know the answer to – i.e. name of dog, mother's maiden name, etc.

Check Component(s) to be used: ☐ NSLP ☐ SFSP ☐ CACFP ☐ Commodities

I understand that the use of the user name and password to access the Idaho State Department of Education – Child Nutrition CNP2000 web site is equivalent to an original signature for purposes of official documentation. By using the user name and password, I certify that the information transmitted is complete and accurate.

To maintain the integrity of the user name and password, they are individually assigned and are not intended to be shared. If another user accesses the system under my user name and password and provides false information, I understand that I will be responsible for the content of the information transmitted to the Idaho State Department of Education.

If I believe that my user name and password have been compromised, I will notify the Idaho State Department of Education – Child Nutrition Program immediately and be assigned a new user name and password.

If access to the CNP2000 system is no longer needed, I understand that it is my responsibility to terminate access.

_____
Signature Authorized User | Name (Please Print) | Date

Superintendent/Director Signature: _____
(Superintendent or director must sign in order for this employee to be considered an authorized signer for claims)

Termination of access: _____
Employee Name to be terminated

Reason: ☐ No longer an employee ☐ Change in job task ☐ Security compromised

Requested by: _____ Date: _____

For State Use Only:

Processed by: _____ Date: _____

NOTE: Please update your Authorized Signer section of the CNP2000 Program to reflect only those currently approved to change the application and approve claims.